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No.

IN THE

Supreme Court of the United States

AETNA U.S. HEALTHCARE, T/A/ HMO-PA,
U.S. HEALTHCARE,

Petitioner,

v.

JONATHAN LAZORKO, AS ADMINISTRATOR OF THE ESTATE OF PATRICIA NORLIE, A/K/A PATRICIA NORLIE-LAZORKO, AND AS PERSONAL REPRESENTATIVE OF PATRICIA NORLIE-LAZORKO,

Respondent.

On Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Third Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether the Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001 *et seq.* ("ERISA"), completely preempts state law direct liability claims against a managed care organization ("MCO") based on a subscriber's alleged receipt of negligent or otherwise inadequate care.

2. Whether ERISA preempts state law vicarious liability claims against an MCO based on the MCO's alleged provision of negligent or otherwise inadequate care through its alleged agents.

PARTIES TO THE PROCEEDING AND RULE 29.6 STATEMENT

The caption contains the names of all of the parties to the proceeding. Petitioner's parent company is Aetna, Inc., a publicly traded company.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner respectfully asks this Court to issue a writ of certiorari to review the judgment of the United States Court of Appeals for the Third Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals (Pet. App. 1a-16a) is reported at 237 F.3d 242 (3d Cir. 2000). The opinion of the district court of November 22, 1995, denying plaintiff's first motion to remand (Pet. App. 17a-18a), is unreported, but may be found at 1995 WL 696888 (E.D. Pa. Nov. 22, 1995). The opinion of the district court of March 28, 1997, denying plaintiff's second motion to remand (Pet. App. 19a-31a), is not reported. The opinion of the district court of June 30, 1998, dismissing the direct claims against Aetna and remanding the vicarious liability claims (Pet. App. 32a-47a), and the opinion of August 10, 1998, denying Aetna's motion for reconsideration (Pet App. 48a-50a), are not reported, but may be found at 1998 WL 405055 (E.D. Pa. June 30, 1998) and 1998 WL 512995 (E.D. Pa. Aug. 10, 1998), respectively.

JURISDICTION

The judgment of the Court of Appeals was entered on December 26, 2000. Pet. App. 2a. On March 19, 2001, Justice Souter extended the time for filing a petition for a writ of certiorari to and including April 25, 2001. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the Constitution of the United States provides:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. CONST. art. VI, cl. 2.

ERISA's civil enforcement provision, § 502(a)(1)(B) of the Act, provides in pertinent part:

> A civil action may be brought * * * by a participant or beneficiary * * * to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan.

29 U.S.C. § 1132(a)(1)(B).

ERISA's express preemption provision, § 514(a) of the Act, provides in pertinent part:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title * * * *

29 U.S.C. § 1144(a).

STATEMENT

1. Petitioner Aetna U.S. Healthcare, t/a/ HMO-PA, U.S. Healthcare ("Aetna" or "Petitioner") operates a federally qualified health maintenance organization ("HMO"), which provides health services to its subscribers on a pre-paid basis. Aetna contracts with employers and others to administer benefits available under

plans established pursuant to the Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, *et seq.* ("ERISA"). In furtherance of that administrative function, Aetna contracts with independent physicians and other providers to deliver healthcare to Aetna subscribers as "participating providers" in Aetna's network. Petitioner does not direct the care furnished by the participating providers, nor does Aetna itself provide any type of medical treatment to its subscribers.[1] Pet. App. 51a-52a.

2. Aetna arranged for healthcare benefits to respondent Jonathan Lazorko and his wife, Patricia Norlie-Lazorko, pursuant to a plan established by respondent's employer under ERISA. Pet. App. 2a-3a. From June 10 to 12, 1993, Ms. Norlie-Lazorko was hospitalized at Pennsylvania Hospital following a suicide attempt. In July 1993, she committed suicide, allegedly as a result of her improperly treated mental illness. Before her suicide, Ms. Norlie-Lazorko had requested that she be hospitalized again. Dr. David Nicklin, an Aetna participating provider, had denied her request after concluding that her circumstances did not warrant additional hospitalization. Pet. App. 4a.

In 1995, respondent (as the personal representative of Ms. Norlie-Lazorko and administrator of her estate) brought suit in Pennsylvania state court against Dr. Nicklin, University City Family Medicine, Pennsylvania

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[1] Aetna arranges and pays for healthcare for its members by contracting with independent physicians and healthcare providers, rather than (as in so-called "staff model" HMOs) through its own salaried employees. The ERISA plan Group Master Contract in this case provides that Aetna's participating providers are not agents or employees of Aetna and are solely responsible for all medical services rendered. Pet. App. 51a-52a.

Hospital, Institute of Pennsylvania Hospital, and Aetna alleging that their improper treatment of Ms. Norlie-Lazorko's mental illness resulted in her suicide. As to Aetna, respondent alleged four counts of liability. In Count I, respondent claimed that Aetna was directly liable under the state law of trespass for his wife's death, because Aetna provided financial incentives to Dr. Nicklin that allegedly discouraged him from granting her request for additional treatment. Pet. App. 4a. In Counts II, III, and IV, respondent claimed that Aetna was directly liable for his wife's death based on Aetna's alleged intentional misrepresentation, fraud, and violation of Pennsylvania's consumer protection law. *Id.* at 6a. In addition, respondent alleged in Count I that Aetna was vicariously liable for Dr. Nicklin's allegedly negligent provision of care. *Id.* at 4a.

Aetna removed the case to federal court, asserting that respondent's claims are completely preempted by ERISA, and thus were removable under this Court's ruling in *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 64-66 (1987). Respondent moved to remand. The district court rejected respondent's motion, reasoning that the complaint "alleged denial of the medical benefits under plaintiff's employer benefit plan," and thus, "is completely preempted by ERISA." Pet. App. 17a. In a subsequent decision, the court dismissed the claims against Aetna "to the extent that [plaintiff's claims] set forth a state-law cause of action for denial of medical benefits by Defendant * * * because they are preempted by section 502(a)(1)(B) of ERISA." *Id.* at 20a. The court remanded the remaining state-law claims to state court. *Id.* at 20a.

3. Following additional rulings by the state court on remand, respondent was permitted to file a new amended complaint. Respondent's new complaint, however, renewed his contention that Aetna's cost containment policies interfered with Dr. Nicklin's medical treatment of Ms. Norlie-Lazorko. *Id.* at 4a-5a. Aetna

accordingly removed the case to federal court a second time.

Respondent again moved for a remand. The district court denied the remand motion, concluding, as it had before, that respondent's claims for denial of hospital benefits were completely preempted by Section 502(a) of ERISA. *Id.* at 26a-27a. Respondent amended his complaint four more times, but did not alter his central contention that untoward incentives allegedly created by Aetna's coverage policies contributed to his wife's death. *Id.* at 5a.

Aetna later moved for summary judgment, arguing that respondent's direct and vicarious liability claims are preempted by ERISA. The court granted Aetna's motion with respect to respondent's direct claims contained in Count I, reasoning that, because those claims "allege[] that U.S. Healthcare's financial incentive system resulted in an economically motivated decision to refuse Ms. Norlie-Lazorko needed care," they "seek tort recovery for a denial of plan benefits based upon U.S. Healthcare's administration of the insurance plan." *Id.* at 40a. The district court also dismissed as preempted by ERISA § 514(a) respondent's direct liability claims contained in Counts II, III, and IV for alleged intentional misrepresentation, fraud, and violation of the state consumer protection law. *Id.* at 44a, 46a. With respect to respondent's vicarious liability claims, the district court, noting that the courts "are divided" on this issue, concluded that "ERISA does not preempt plaintiff's claim that U.S. Healthcare is vicariously liable for any malpractice committed by its agents," and remanded those claims to state court. *Id.* at 41a, 46a.

4. Respondent appealed the dismissal of his direct claims and Aetna cross-appealed the district court's remand to state court of the vicarious liability claims. The Third Circuit reversed the dismissal of the direct claims contained in Count I, directing the district court to remand those claims to the state court; affirmed the dis-

missal of the direct claims contained in Counts II, III, and IV for alleged intentional misrepresentation, fraud, and violation of the state consumer protection law; and affirmed the district court's remand to state court of the vicarious liability claims.[2]

The court began its analysis by observing that ERISA's civil enforcement provision, § 502(a)(1)(B); 29 U.S.C. § 1132(a)(1)(B), completely preempts claims for the denial of benefits under an ERISA plan, and that removal jurisdiction over such claims is thus proper. Pet. App. 10a (citing *Taylor*, 481 U.S. at 63-64).

The court then analyzed whether respondent's direct claims contained in Count I (alleging that Aetna's cost containment incentives interfered with Dr. Nicklin's medical treatment of Ms. Norlie-Lazorko) are completely preempted under Section 502(a) of ERISA and concluded that they are not. *Id.* at 11a. The court relied on a line of Third Circuit authority beginning with *Dukes v. U.S. Healthcare*, 57 F.3d 350 (3d Cir. 1995), in which the court had distinguished between claims directed to the "quality of [the] benefit[s] [plaintiffs] received," which the Third Circuit believes fall outside the scope of Section 502(a)'s enforcement provisions, and claims that an MCO "withheld some quantum of plan benefits due" under an ERISA plan, which are completely preempted under Section 502(a). *Id.* at 356-57; *see also In re U.S. Healthcare*, 193 F.3d 151, 161-64 (3d Cir. 1999), *cert. denied*, 530 U.S. 1242 (2000) (finding no complete preemption of claims that "do not involve an attempt to recover benefits due, enforce rights, or clarify future benefits under a plan, but rather seek recovery under 'the quality standard found in the other-

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[2] Respondent also appealed the district court's award of sanctions against his attorney, which the Third Circuit dismissed for lack of appellate jurisdiction. Pet. App. 9a.

wise applicable [state] law.'") (citation omitted). Applying the quality-quantity distinction to respondent's claim that Aetna's policies improperly interfered with Dr. Nicklin's medical judgment, the court concluded that the gravamen of that claim was not the denial of plan hospitalization benefits to Ms. Norlie-Lazorko, but "the propriety of care" given to her. Pet. App. 13a. The court noted that "drawing the line between the denial of benefits under a plan and the provision of substandard care is difficult," but concluded that respondent's claims, "as [they] ha[ve] been pled, fall[] on the standard of care, not the denial of benefits, side of the line." *Id.* at 14a.

The court of appeals also rejected Aetna's reliance on this Court's decision in *Pegram v. Herdrich*, 530 U.S. 211 (2000), which recognized the centrality of financial incentives to managed care and Congress's approval of such cost control systems. The court of appeals noted that the decision challenged by respondent—whether to hospitalize Ms. Norlie-Lazorko—was a "mixed decision" involving both eligibility for benefits and medical treatment. Pet. App. 14a. *Pegram* held that such mixed decisions may not be the basis for a fiduciary breach claim under ERISA, though they are of course coverage decisions under that statute. The court, however, concluded that "to the extent that the mixed decision implicates the quality of the care received by Norlie-Lazorko, *Pegram* does not foreclose the direct claims against U.S. Healthcare." *Id.*

Next, the court affirmed the dismissal of the direct claims for liability contained in Counts II, III, and IV—those charging Aetna with intentional misrepresentation, fraud, and violation of the state consumer protection law—because respondent did not argue that those claims "are directed at the quality, rather than the quantity, of benefits received under his plan." *Id.* at 6a n.4. The court thus necessarily held that removal jurisdiction was proper based on ERISA's complete preemption of those claims, but failed to explain how that conclusion could

be reconciled with its view that the case was improperly removed to federal court. *Id*; *see also* 28 U.S.C. § 1367.[3]

Finally, the court affirmed the district court's remand of the vicarious liability claims against Aetna, declining to reach the issue whether respondent's vicarious liability claims are preempted by ERISA § 514(a). Pet. App. 16a. The court reasoned that, because it concluded that the direct claims contained in Count I are not completely preempted by ERISA § 502(a), the district court lacked removal jurisdiction and the entire case must be remanded. *Id.* at 15a, 16a.

REASONS FOR GRANTING THE WRIT

In *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), this Court unanimously held that ERISA preempted state law tort and contract claims against an insurer for failing to provide certain disability benefits under an ERISA plan in "bad faith." *Id.* at 43, 57. Although the tort of bad faith had long been used to seek damages for wrongful benefit denials, *Pilot Life* concluded that permitting such a cause of action would amount to giving plan beneficiaries an alternative enforcement mechanism for contesting the denial of benefits. *Id.* at 54, 57. As the Court explained, any state-law cause of action that amounts to such an alternative enforcement action is preempted by ERISA, because Congress clearly intended for the remedies set forth in ERISA § 502(a) to be exclusive:

> [T]he detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that

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[3] *See also* Pet. App. 7a n.5 (stating that the district court properly struck several of the complaint's allegations because that court "had § 502(a) removal jurisdiction.").

> represents a careful balancing of [policy choices]. The policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA.

Id. at 54, 57. As the Court also emphasized, Congress clearly intended that all suits for improper processing of plan benefits be treated as "federal questions governed by § 502(a)," even if the state action "purports to authorize a remedy" not provided by § 502(a). *Id.* at 55, 56.

On the same day that the Court decided *Pilot Life*, the Court also decided *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58 (1987). Building on *Pilot Life's* basic premise that all claims for refused or mishandled ERISA benefits are necessarily federal in character, *Taylor* unanimously held that such claims may be removed to federal court under the doctrine of "complete preemption," even if the suit "purports to raise only state law claims."[4] *Taylor*, 481 U.S. at 65, 67. Accordingly, alternative enforcement mechanisms to § 502(a)'s exclusive remedies "arise[] under the * * * laws * * * of the United States" "by virtue of the clearly manifested intent of Congress" in enacting ERISA. *Id.* at 67 (citation omitted).

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[4] Under the doctrine of complete preemption, when Congress "so completely pre-empt[s] a particular area that any civil complaint raising this * * * claim[] is necessarily federal in character," such claims are removable to federal court regardless of the underlying theory of the claim. *Taylor*, 481 U.S. at 63-64, 67.

I. THE DECISION BELOW EXACERBATES AN EXISTING CONFLICT AMONG THE COURTS OF APPEALS REGARDING WHETHER ERISA COMPLETELY PREEMPTS DIRECT LIABILITY CLAIMS AGAINST MCOs

Respondent's direct liability claims against Aetna, like the state law claims for denial of benefits found to be preempted in *Pilot Life* and *Taylor*, constitute an impermissible attempt to challenge an ERISA benefits determination under state law, in derogation of the exclusive remedies prescribed by ERISA § 502(a). If respondent were to prevail on his direct liability claims against Aetna, Aetna would effectively be required to cover claims not in accordance with Aetna's best judgment of what plan documents require, and subject to review under federal standards, *see Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 114-15 (1989), but in accordance with the vagaries of countless conceivable state-law causes of action. Indeed, the decision below effectively gives plan beneficiaries the federal scheme under an amorphous and manipulable "quality or quantity" test that attaches dispositive significance to how claims are "presently pled." Pet. App. 14a. That approach not only conflicts with the rulings of the majority of courts of appeals that have considered the question, but also is inherently at odds with this Court's recognition that the whole point of the complete preemption doctrine is to disregard artful and evasive pleading maneuvers.

1. The majority of courts to consider the issue have concluded that ERISA § 502(a) completely preempts state law claims against an MCO for the alleged provision of negligent care. For example, in *Danca v. Private Health Care Systems, Inc.*, 185 F.3d 1 (1st Cir. 1999), the First Circuit held, in circumstances strikingly similar to those at issue here, that state law claims against an MCO for allegedly providing substandard care fall within the scope of ERISA § 502(a) and are therefore

completely preempted. *Id.* at 6 (citing *Pilot Life*, 481 U.S. at 56). As in this case, the plan beneficiary in *Danca* had requested treatment for her mental illness and had later attempted suicide, allegedly as a result of the "totality of her inadequate care," including the MCO's allegedly negligent decision to deny her pre-certification request for hospitalization at a particular hospital. *Id.* at 4. The court explained that, although "the allegedly negligent decisionmaking and consultation may be characterized as medical in nature,"

> [w]hat matters * * * is that the conduct was indisputably part of the process used to assess a participant's claim for a benefit payment under the plan. As such, *any state-law-based attack* on this conduct would amount to an 'alternative enforcement mechanism' to ERISA's civil enforcement provisions contained in ERISA § 502(a) * * *.

Id. at 6 (emphasis added).

In *Tolton v. American Biodyne, Inc.*, 48 F.3d 937 (6th Cir. 1995), the Sixth Circuit reached a similar conclusion with respect to a host of state claims—including wrongful death, medical malpractice, and insurance bad faith—leveled against CIGNA, as plan administrator, as a result of its failure to authorize in-patient treatment of a beneficiary who later committed suicide. *Id.* at 939-40, 941. Whatever the legal label invoked by the plaintiff, the court ruled, those claims essentially arose "from an allegedly improper denial of benefits," and thus were completely preempted under *Pilot Life* and *Taylor*. *See id.* at 941-43.[5]

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[5] As the Sixth Circuit also recognized in *Tolton*, a finding of complete preemption gains further support where—as was the case here—plaintiff brings the case as a representative of the beneficiary's estate. 48 F.3d at 941.

The Eighth Circuit has likewise held that a state law claim against an MCO for allegedly improper medical care "is completely preempted by ERISA [§ 502(a)'s] remedies." *Thompson v. Gencare Health Systems, Inc.*, 202 F.3d 1072, 1074 (8th Cir. 2000). The plaintiff in *Thompson* alleged "medical malpractice in refusing 'to perform and/or provide [certain treatments],'" because the MCO denied a pre-certification request for the treatment. *Id.* at 1073. The court explained that, as construed in *Pilot Life*, "ERISA completely preempts a state law medical malpractice claim when 'the essence of [the] claim rests on the denial of benefits.'" *Id.* (citation omitted). The court concluded that the plaintiff was "assert[ing] a tort claim for damages on account of [the MCO's] allegedly wrongful benefits decisions as plan administrator," and thus held the claim completely preempted by ERISA § 502(a). *Id.* at 1074; *see also Hull v. Fallon*, 188 F.3d 939, 943 (8th Cir. 1999) ("[A]lthough [the plaintiff's] characterization of his claims sound[s] in medical malpractice, the essence of his claim rests on the denial of benefits."); *Kuhl v. Lincoln Nat'l Health Plan of Kansas City, Inc.*, 999 F.2d 298, 303 (8th Cir. 1993) (holding that plaintiff's claim against an MCO for allegedly improper delay of treatment fell within § 502(a)).

Similarly, in *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992), the Fifth Circuit held that ERISA preempts "a state-law malpractice action brought by the beneficiary of an ERISA plan" against an MCO for allegedly "wrongfully den[ying] appropriate medical care" (*id.* at 1322, 1326) in declining to pre-certify a request for hospitalization. *Id.* at 1322, 1324. Relying on *Pilot Life*, the court reasoned that plaintiff's suit essentially sought to challenge a "benefit determination" and

was therefore preempted. *Id.* at 1332.[6] The court reasoned that, although the MCO "makes medical decisions—indeed, [it] gives medical advice—* * * it does so in the context of making a determination about the availability of benefits under the plan." *Id.* at 1331. Accordingly, the court concluded, the state tort action for the MCO's "allegedly * * * erroneous medical decision is pre-empted by ERISA." *Id.* (citing *Pilot Life*).

A number of other circuit courts have also held that state-law direct liability claims against MCOs for allegedly negligent provision of care are completely preempted by ERISA § 502(a). *See, e.g., Parrino v. FHP, Inc.*, 146 F.3d 699, 702-03 (9th Cir. 1998) (state law claim against an MCO for allegedly improper failure to provide appropriate therapy "fall[s] within the scope of Section 502(a)(1)(B) [and is] completely preempted"); *Cannon v. Group Health Svc. of Oklahoma, Inc.*, 77 F.3d 1270, 1273-75 (10th Cir. 1996) (claim against an MCO for allegedly negligent "refus[al] to authorize" medical treatment preempted by ERISA § 502(a)) (citing *Pilot Life*, 481 U.S. at 57, and *Taylor*, 481 U.S. at 62-63).[7]

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[6] Although the court spoke in terms of ERISA preemption rather than complete preemption, a careful reading of the court's opinion reveals that it concluded that the state law claim fell within the scope of § 502(a) as a claim for a "benefit determination." *Id.* at 1332; *see also Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1490 n.5 (7th Cir. 1996) ("Although the [*Corcoran*] court did not distinguish between 'complete preemption' and 'conflict preemption,' a thorough reading of that opinion demonstrates that the court had concluded that [plaintiff's] claim was really an ERISA claim and 'completely preempted.'"); *Dukes*, 57 F.3d at 360 (same).

[7] Similarly, in *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482 (7th Cir. 1996), the Seventh Circuit held that a

[Footnote continued on next page]

The Second Circuit, by contrast, has reached a conclusion in line with the analysis employed by the Third Circuit in this case. In *Lupo v. Human Affairs International, Inc.*, 28 F.3d 269 (2d Cir. 1994), the Second Circuit concluded that a state law claim against an MCO for the alleged provision of substandard care is not completely preempted by ERISA § 502(a). *Id.* at 272. The plaintiffs in *Lupo* alleged that the managed care company was directly liable for a plan beneficiary's receipt of allegedly improper care because the MCO negligently hired and supervised a doctor alleged to have engaged in improper psychotherapy treatment. *Id.* The court reasoned that, because "none of the[] claims bears any significant resemblance to those described in [ERISA § 502(a)(1)(B); 29 U.S.C.] § 1132(a)(1)(B)," (*id.* at 272) "the district court lacked removal jurisdiction over this action." *Id.* at 270.

[Footnote continued from previous page]
state law direct liability claim against an MCO's utilization review administrator for the allegedly negligent provision of treatment is completely preempted by ERISA § 502(a). 88 F.3d at 1490. The plaintiff in *Jass* claimed that a registered nurse performing utilization review for an MCO "negligently and carelessly failed to see that the plaintiff received appropriate [treatment.]" *Id.* at 1488. The court held that the allegedly negligent "determin[ation] that said course of treatment was not medically necessary" and the resulting decision to discharge the plaintiff from the hospital "was a determination of benefits within the meaning of ERISA." *Id.* at 1489 (internal quotation marks omitted). As such, the state law claim was "in effect a claim for denial of benefits" under § 502(a) and was completely preempted. *Id.* at 1489, 1490-91. The court also held that a vicarious liability claim against the MCO for the alleged negligent provision of treatment by the utilization review administrator was completely preempted by § 502(a). *Id.* at 1491.

2. As a majority of the courts of appeals have recognized, this Court's decisions in *Pilot Life* and *Taylor* require preemption, and permit removal, of all state-law challenges to the denial of plan benefits, without regard to the plaintiff's underlying theory of the claim. *Pilot Life*, 481 U.S. at 55, 56; *Taylor*, 481 U.S. at 65, 67. Indeed, this Court's decisions require courts to look beyond the face of the complaint to determine whether a claim, even if artfully pleaded in an attempt to escape preemption, properly should be recharacterized as one arising under § 502(a) because the claim "is necessarily federal in character." *Taylor*, 481 U.S. at 63-64; *see also Pilot Life*, 481 U.S. at 55, 56 ("[A]ll suits brought by beneficiaries * * * asserting improper processing of claims under ERISA-regulated plans [are] treated as federal questions governed by § 502(a)," "even when the state action purport[s] to authorize a remedy unavailable under the federal provision."); *Federated Dep't Stores, Inc. v. Moitie*, 452 U.S. 394, 397 n.2 (1981) (it is a "settled principle" that courts look beyond the face of the complaint "to determine whether the real nature of the claim is federal, regardless of plaintiff's characterization.").[8]

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[8] *See also Jass*, 88 F.3d at 1489 (noting that a plaintiff cannot avoid complete preemption by "'artful pleading' sought to defeat defendant's right to a federal forum" if the claim is "best recharacterized as a 502(a)(1)(B) claim to recover benefits due under the terms of the plan.") (citing *Taylor*, 481 U.S. at 64); *Parrino*, 146 F.3d at 704 ("Because complete preemption often applies to complaints drawn to evade federal jurisdiction, a federal court may look beyond the face of the complaint to determine whether the claims alleged as state law causes of action in fact are necessarily federal claims."); *Hull*, 188 F.3d at 943 ("although [plaintiff's] characterization of his claims sound[s] in medical malpractice," the claims "in "essence * * * rest[] on the de-

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By granting talismanic significance to how a plaintiff chooses to characterize his own claim, the decision below plainly runs afoul of these principles. Respondent sought recovery against Aetna based on the allegedly negligent decision of Dr. Nicklin to deny Ms. Norlie-Lazorko's request to be hospitalized. Hospitalization is a benefit under respondent's ERISA plan. The essence of this claim is clearly a claim under Section 502(a) for denial of hospitalization benefits under respondent's plan. *See Taylor*, 481 U.S. at 62-63 ("[A] suit by a beneficiary to recover benefits from a covered plan[] * * * falls directly under § 502(a)(1)(B) of ERISA."). As other circuits have recognized in analogous circumstances, such a claim, "regardless of plaintiff's characterization" (*Moitie*, 452 U.S. at 397 n.2) "is necessarily federal in character." *Taylor*, 481 U.S. at 63-64.

Moreover, even by respondent's own reckoning, his direct claims against Aetna are based solely on the fact that Aetna provided a system of financial incentives to its participating providers, including Dr. Nicklin. Aetna arranges and pays for healthcare for its members by contracting with independent physicians, rather than through its own salaried employees. Aetna does not direct the care furnished by the participating providers, nor does Aetna itself provide any type of medical treatment to its members. There can be no question that Aetna's conduct in establishing a system of cost control incentives for its participating providers was a pure administrative decision regarding the coverage of benefits and the system by which those plan benefits are to be administered. As such, any direct liability claim premised on Aetna's establishment of such an administrative system

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nial of benefits" under § 502(a)."); *Kuhl*, 999 F.2d at 303 (despite plaintiff's attempt to "artful[ly] plead[]" a state law "malpractice" claim, plaintiff's claim fell within § 502(a)).

to ration care, and the system's influence on a care provider's denial of requested plan benefits, is necessarily a claim for the administrative denial of plan benefits under § 502(a).

Nevertheless, the court below based its holding to the contrary on its view that the "direct claims, *as they are presently pled*, challenge the soundness of a medical decision by a health care provider rather than the administration of benefits under an ERISA plan." Pet. App. 11a (emphasis added). The court relied on respondent's characterization of his direct claims, stating that, "Lazorko is not arguing that his plan is supposed to permit hospitalizations for mental illness and that U.S. Healthcare refused his wife's request for guaranteed service." *Id.* at 13a; *see also id.* at 14a ("Lazorko's claim, *as it has been pled*, falls on the standard of care, not the denial of benefits, side of the line.") (emphasis added). Indeed, the court noted that, "[o]n remand, it will be for the state court to determine whether a § 502 claim of denial of a benefit provided by his plan is *lodged in the heart* of Lazorko's direct claims." *Id.* at 15a (emphasis added).

By accepting at face value respondent's characterization of his claims "as they are presently pled," and avoiding ERISA's requirement to determine whether these claims are in reality "necessarily federal in character" (*Taylor*, 481 U.S. at 63-64), the decision below is clearly inconsistent with the teachings of this Court in *Taylor* and *Pilot Life*. Quite simply, respondent's complaint, although "purport[ing] to raise only state law claims," cannot alter the indisputable fact that respondent seeks, in essence, to recover for harm allegedly caused as a result of Dr. Nicklin's denial of hospitalization benefits, as influenced by Aetna's administrative system of benefit cost controls. *Taylor*, 481 U.S. at 65,

67. These direct liability claims are clearly within the ambit of ERISA § 502(a), as interpreted by this Court in *Taylor* and *Pilot Life*.[9]

II. THE COURTS OF APPEALS ARE DIVIDED OVER THE QUESTION WHETHER ERISA PREEMPTS STATE LAW VICARIOUS LIABILITY CLAIMS AGAINST MCOs FOR ALLEGEDLY PROVIDING INADEQUATE CARE THROUGH THEIR ALLEGED AGENTS

As the district court noted in this case, the question whether ERISA preempts state law vicarious liability claims against an MCO for the alleged provision of negligent care through its alleged agents has led to conflicting decisions among the federal courts of appeals. Pet. App. 41a. Indeed, other federal courts have also noted

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[9] This Court currently has before it two cases that raise the issue of the proper scope of *Pilot Life*'s holding that ERISA completely preempts all state law claims that constitute alternative enforcement mechanisms to ERISA § 502(a). *Corporate Health Ins., Inc v. Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000), *pet'n for cert. filed*, 69 U.S.L.W. 3317 (U.S. Oct. 24, 2000) (No. 00-665); *Moran v. Rush Prudential HMO, Inc.*, 230 F.3d 959 (7th Cir. 2000), *pet'n for cert. filed*, 69 U.S.L.W. 3459 (U.S. Dec. 22, 2000) (No. 00-1021). This Court invited the Solicitor General to file briefs in these cases expressing the views of the United States. *Montemayor v. Corporate Health Ins., Inc.*, 121 S. Ct. 753 (Jan. 8, 2001); *Rush Prudential HMO, Inc. v. Moran*, 121 S. Ct. 1400 (March 26, 2001). Because the decision of the court below rests on that court's conclusion that respondent's state law direct liability claims contained in Count I do not constitute an alternative enforcement mechanism under § 502(a), if this Court declines to grant plenary review in this case, it should hold the petition pending its consideration and eventual disposition of the petitions in *Montemayor* and *Moran*.

the longstanding division of authority on this question. *Pacificare of Oklahoma, Inc. v. Burrage*, 59 F.3d 151, 153 (10th Cir. 1995) ("'[T]he split among courts exemplifies the difficulty [of] this preemption issue.'") (citation omitted); *id.* ("[I]t is evident that 'reasonable and capable people may differ' over this question of preemption.") (citation omitted). Nonetheless, without expressly discussing the issue, the Third Circuit simply affirmed the district court's decision to follow "the reasoning of such cases as * * * *Burrage*." Pet. App. 41a; *see also id.* at 16a.[10]

1. The Third Circuit's decision is consistent not only with the Tenth Circuit's decision in *Burrage*, but also with the Fifth Circuit's decision in *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 215 F.3d 526 (5th Cir. 2000), *pet'n for cert. pending on other issues*, No. 00-665. In *Corporate Health*, the Fifth Circuit con-

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[10] The Tenth Circuit in *Burrage* concluded that ERISA does not preempt state law vicarious liability claims against MCOs alleging negligent provision of care. *Burrage*, 59 F.3d at 155. At issue in *Burrage* was a state law claim alleging that an HMO is "vicariously liable for the medical malpractice of [the treating physician, an] alleged agent of [the HMO.]" *Id.* at 152. The Tenth Circuit reasoned that the claim "does not involve the administration of benefits or the level or quality of benefits promised by the plan; the claim alleges negligent care by the doctor and an agency relationship between the doctor and the HMO." *Id.* at 155. The court noted that, "[j]ust as ERISA does not preempt the malpractice claim against the doctor, it should not preempt the vicarious liability claim against the HMO if the HMO has held out the doctor as its agent." *Id.* In addition, the court explained that "reference to the plan to resolve the agency issue does not implicate the concerns of ERISA preemption." *Id.* Thus, the court concluded, the state law vicarious liability claim did not "relate to" an ERISA plan within the meaning of § 514(a). *Id.* at 153-55.

cluded that ERISA preemption does not apply to state law vicarious liability claims against an MCO based on the alleged negligent provision of care by one of the MCO's alleged agents. *Id.* at 535. At issue in *Corporate Health* was a Texas law that authorizes "suit for claims that a treating physician was negligent in delivering medical services, and * * * [that] imposes vicarious liability on managed care entities for that negligence." *Id.* at 534. The court held that "[t]his vicarious liability does not 'relate to' the managed care provider's role as an ERISA plan administrator or affect the structure of the plans themselves so as to require preemption." *Id.* at 534. The court reasoned that, "[a]lthough state efforts to regulate an entity in its capacity as plan administrator are preempted, managed care providers operate in a traditional sphere of state regulation when they wear their hats as medical care providers."[11] *Id.* Finding the state cause of action to fall in the latter category, the court thus concluded that ERISA does not preempt vicarious liability claims against an MCO for alleged malpractice. *Id.*

2. The treatment of the vicarious liability claim in *Burrage, Corporate Health*, and the decision below conflicts with the approach adopted by the Seventh Circuit in *Jass*. The *Jass* court concluded that a vicarious liability claim against an MCO for its physician's alleged negligence "relates to" an ERISA plan within the meaning of § 514(a). *Jass*, 88 F.3d at 1493. The court reasoned that, if the alleged agency relationship existed between the MCO and the physician, "it was solely as a result of the [MCO's] health care plan of which [the

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[11] *See also id.* at 534 ("ERISA preempts malpractice suits against doctors making coverage decisions in the administration of a plan, but it does not insulate physicians from * * * [state] professional standards regarding medical decisions").

plaintiff] was a participant." *Id.* at 1493. The court also observed that any determination of whether such an agency relationship exists "would require an examination of the health care plan to determine the relationship between [the physician], [the MCO] and [the plaintiff.]" *Id.*

Moreover, the Seventh Circuit explained, to allow a plaintiff's vicarious liability claim to withstand ERISA preemption "would conflict with Congress' intent in passing ERISA." *Id.* Specifically, such a claim would conflict with Congress's intent to "exclude[] remedies against a plan for compensatory damages resulting from the denial of benefits." *Id.* The state law claim would also conflict with Congress's intent that ERISA plans not be subject to a myriad of state laws, because "[t]o allow a vicarious liability claim against an ERISA Plan for the alleged negligence of a listed physician would require multi-state plans to vary their plan administration to avoid strict vicarious liability under differing state laws." *Id.* at 1494. Thus, the Seventh Circuit held that "the vicarious liability claims against [the HMO] for [the doctor's] alleged negligence * * * 'relate to' the benefit plan and as such are preempted by § 514." *Id.* at 1495.

3. The Third Circuit's ruling on the vicarious liability question also conflicts with a host of this Court's decisions.

This Court has "observed repeatedly that [ERISA's] broadly worded [pre-emption] provision is 'clearly expansive.'" *Egelhoff v. Egelhoff*, 121 S. Ct. 1322, 1327 (2001) (quoting *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655 (1995)). ERISA's preemption provision states that ERISA "shall supersede any and all State laws insofar as they * * * relate to any employee benefit plan." ERISA § 514(a); 29 U.S.C. § 1144(a). As this Court reaffirmed in *Travelers*, "§ 514 indicates Congress's intent to establish the regulation of employee

welfare benefit plans 'as exclusively a federal concern.'" *Travelers*, 514 U.S. at 656 (citation omitted). To that end, Section 514(a) preempts any state law that has a "connection with" or "reference to" such a plan. *Egelhoff*, 121 S. Ct. at 1327 (citation omitted).

A state law has a "connection with" and "relates to" an ERISA plan if it would "preclude uniform administrative practice or the provision of a uniform interstate benefit package." *Travelers*, 514 U.S. at 659-60. As this Court explained in *Travelers*, "[t]he basic thrust of the pre-emption clause * * * was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Travelers*, 514 U.S. at 657; *see also Egelhoff*, 121 S. Ct. at 1328. And as the *Jass* court recognized, state law vicarious liability claims against an MCO for the alleged negligence of a treating physician would run afoul of these congressional goals. *Jass*, 88 F.3d at 1494.

A state law also has a "connection with" and "relates to" an ERISA plan if it would "mandate[] employee benefit structures or their administration" or "bind plan administrators to a[] particular choice." *Travelers*, 514 U.S. at 658-59; *see also California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 332-34 (1997). Vicarious liability claims would have these forbidden effects, because they would compel MCOs to administer their plans and structure their benefits so as to comply with the particular state-created standards of agency and proper care. Like the state laws held preempted by ERISA in *Shaw*, *Holliday*, and *Alessi*, state law vicarious liability claims would require MCOs to pay specific benefits deemed by a state to be necessary to the provision of adequate care. *Trav-*

elers, 514 U.S. at 657-58.[12] MCOs would thus be forced to tailor their plans and benefits "to the peculiarities of the law [regarding the proper standard of care] of each jurisdiction," an outcome "fundamentally at odds with the goal of uniformity that Congress sought to implement." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990).

Moreover, as the Seventh Circuit recognized in *Jass*, state law vicarious liability claims "relate to" an ERISA plan because any alleged agency relationship between an MCO and a physician would be solely as a result of the MCO's healthcare plan, of which the plaintiff was a beneficiary. *Jass*, 88 F.3d at 1492. To determine whether an agency relationship existed would require an examination of the healthcare plan to determine the relationship between the physician, the MCO, and the plaintiff. In this case, for example, the ERISA plan Group Master Contract provides that Aetna's participating providers are not agents or employees of Aetna and are solely responsible for all medical services rendered. Pet. App. 51a-52a; *see also Ingersoll-Rand Co.*, 498 U.S. at 139-40 (holding that a state law wrongful discharge action under state tort and contract law "related to" a benefits plan because "the existence of a pension plan is a critical factor in establishing liability" under the state law).

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[12] *See Travelers*, 514 U.S. at 656-58 (citing *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 97 (1983), *FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990), and *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 524 (1981), in which ERISA preempted state laws that would require ERISA plans to pay specific benefits, (*Shaw*, 463 U.S. at 97) or that attempted to prevent ERISA plans from structuring themselves to pay benefits in a certain manner (*Shaw*, 463 U.S. at 97; *Holliday*, 498 U.S. at 60; *Alessi*, 451 U.S. at 524)).

Because a court considering a state law vicarious liability claim against an MCO for the alleged negligence of a treating physician would look to the healthcare plan in determining whether an agency relationship existed, the cause of action "relates to" an ERISA plan within the meaning of § 514(a) and this Court's holding in *Ingersoll-Rand*. The Third Circuit clearly erred in reaching the contrary conclusion.

III. THE QUESTIONS PRESENTED ARE OF RECURRING AND SUBSTANTIAL IMPORTANCE

As the lower federal courts have recognized, the questions presented by this petition are frequently recurring and exceedingly important. *See, e.g.*, *Thompson*, 202 F.3d at 1073 (observing that the question whether ERISA completely preempts claims against MCOs for allegedly providing inadequate care "is a recurring legal issue"); *Burrage*, 59 F.3d at 153 ("'[T]he split among courts [regarding whether ERISA preempts state law vicarious liability claims against MCOs based on the alleged negligent provision of care] exemplifies the difficulty [of] this preemption issue.'") (citation omitted). Indeed, according to the U.S. Department of Labor, approximately 125 million individuals, representing more than 70% of the workforce and about two-thirds of the entire non-elderly population, are covered under group health plans in the U.S. today. The great majority of these individuals are covered under plans subject to ERISA.

This Court has repeatedly recognized the importance of ERISA, as well as the increasing volume and significance of ERISA preemption questions: "ERISA pre-emption cases reflect[] the comprehensive nature of the statute, the centrality of pension and welfare plans in the national economy, and their importance to the financial security of the Nation's work force." *Boggs v. Boggs*, 520 U.S. 833, 839 (1997); *see also id.* at 836 (stating that the ERISA preemption question is "of un-

doubted importance"). Since ERISA's enactment over 26 years ago, questions regarding the scope of ERISA's preemptive reach have generated "an avalanche of litigation in the lower courts" and "have been the focus of considerable attention from this Court." *De Buono v. NYSA-ILA Medical and Clinical Servs. Fund*, 520 U.S. 806, 808 n.1 (1997); *see also id.* (noting that, "in the 16 years since we first took up the question, we have decided no fewer than 13 cases").

More recently, significant changes in the U.S. healthcare delivery system have generated new questions, including the questions presented here, regarding ERISA preemption and the ability of states to regulate benefits and coverage decisions by MCOs. In 1974 when ERISA was enacted, the majority of employees were covered by "fee-for-service" health plans. Since that time, legislative efforts to control rising medical costs have resulted in the transformation of the American healthcare system, as insurers and others developed new models for financing and providing healthcare. Today, most ERISA plans have moved to managed care systems such as HMOs, which employ various cost control measures, including utilization review and financial incentives to physicians to encourage treatment rationing. *Pegram v. Herdrich*, 530 U.S. 211, 219 (2000).

Those transformations have engendered significant confusion and conflict among the federal courts of appeals, as they have attempted to apply ERISA's provisions to the managed care marketplace of today. As the large number of court decisions addressing these questions and the ever-increasing split of authority regarding them attest, these issues arise with great frequency and clearly warrant this Court's attention.

CONCLUSION

The petition for a writ of certiorari should be granted.

Respectfully submitted.

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